Sponsorship Number _____

APPENDIX III

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
HEALTH OCCUPATIONS CREDENTIALING

Course Information Sheet

Course Type (Select then press Tab to continue)

Course Delivery (Select then press Tab to continue)

Primary Instructor Name: _____

Current Address: _____
Street City State Zip

Current Phone Number: _____ E-Mail address: _____

Instructor ID# _____ KS RN Licensure Expiration Date _____

Sponsor Name: _____ Facility/School ID # _____

Address: _____
Street City State Zip

Current Phone Number: _____ E-Mail address: _____

Classroom: _____

Address: _____
Street City State Zip

Clinical: _____ Facility ID # _____

Address: _____
Street City State Zip

Course Begins _____ Course Ends _____

Class Days & Times _____

I hereby attest that the information supplied above is accurate and complete. I have verified that the clinical facility does not have a ban on training and that the instructor is approved for the type of course and has a currentlicense.

_____ _____
Coordinator Signature Date

_____ _____
Instructor Signature Date

DEPARTMENT USE ONLY

Clinical Site Approved Yes No _____/_____/_____ Course Approval Number_____